RECURRENCE OF RETROPERITONEAL LIPOMA : OPERATION : RECOVERY.*

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In the *BRITISH MEDICAL JOURNAL* of December 2nd, 1905, I reported a case of retroperitoneal lipoma weighing 21 lb., situated in intimate relation to the right kidney and ureter, which I removed with ease, the tumour shelling out of its bed apparently completely.

The patient, a woman aged 40, rapidly recovered from the operation, and put on flesh. She remained in perfect health for about two years, but at the end of that time, eight months before I saw her again, she began to suffer from stomach troubles, and from slight pain in the back and sides. Two months later the abdomen began to swell, and these symptoms went on for six months, when she consulted Dr. Kirkhope of Belfast, who sent her to me. She came into hospital on March 2nd, 1907. Her appearance on admission was much better than when she first came under my care, she was much fatter and more healthy looking. I found the abdomen distended and filled with a lobulated tumour; the individual masses were firm in consistence, one in the epigastrium in particular was so hard that I was led to fear that the recurrence which was evidently present was of a malignant type. During the four days which she passed in hospital before operation she was quite free from symptoms of any kind. It is interesting to note that the scar of the first operation, which measured over 9 in. in length, showed no signs of yielding.

On March 6th I opened the abdomen by an incision of about 9 in. in length, and found the following state of affairs: The tumour consisted of a number of lobes varying in size from that of a goose-egg up to that of a Rugby football, more or less pedunculated, and only united at their common site of origin, which was in the right flank in the angle between the outer border of the kidney and the iliac crest. The right colon lay internal to this, and several large vessels ran from its outer border into the pedicle. One small mass, burrowing beneath the caecum, had opened up the layers of the meso appendix, and extended into the iliac fossa. I removed all the masses, some for convenience sake being tied off and separated from the pedicle, and completely cleared away the perirenal fat, leaving the quadratus lumborum bare. I also removed the appendix when enucleating the mass which I have described as burrowing beneath it and the caecum. The peritoneum was then sutured over the denuded muscles, and the abdominal wound closed. Recovery was uneventful, and the patient left hospital on the twenty-first day after operation. I need hardly say that I shall keep a careful watch over her future history.

The tumour masses weighed altogether 12½ lb., were pinkish-white in colour when fresh, and microscopically showed typical lipomatous tissue, with no trace of malignancy.

The case is of considerable interest, both on account of the rarity of the original condition and also on account of the recurrence. Adami,¹ in his monograph on retroperitoneal lipoma, was able to collect 42 cases. Of these 26 were operated on, with only 12 recoveries. In one of these cases recurrence took place, but I do not know whether this case was operated on again or not.

I was surprised at the recurrence in my case, as the first growth shelled out with so little trouble, and as the tumour, which has been preserved, shows no cut or torn surface anywhere, and seems altogether encapsuled. I do not think the secondary growth can be malignant, both on account of the negative microscopic finding and also because there were no signs of haemorrhage or degeneration such as are almost invariably present in retroperitoneal sarcomata which have attained any considerable size. The clinical evidence, absence of cachexia, of loss of weight, and of signs of metastasis, is also entirely against any presumption of malignancy.

REFERENCE.

¹Adami, *Montreal Medical Journal* (January and February, 1897). Quoted in Nothnagel (English edition), *Diseases of the Intestines and Peritoneum*.

* Read before the Ulster Branch of the British Medical Association.

THE late Miss Caroline Everard of Salisbury, who died on August 28th, left £1,000 each to the Norfolk and Norwich Hospital; the Royal Hospital for Incurables, Putney; the Asylum for Idiots, Earlswood; and the Hospital for Consumption, Fulham Road; £800 to the British Home for Incurables; and £500 each to the South London Ophthalmic Hospital; the National Hospital for the Paralysed and Epileptic; Salisbury Infirmary; the Seamen's Hospital, Greenwich; and the West London Hospital.

A CASE OF RETROPERITONEAL HAEMATOCELE PRODUCING ACUTE INTESTINAL OBSTRUCTION.

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RETROPERITONEAL haematocoele is a somewhat rare condition, and intestinal obstruction of acute character in association therewith is rarer still. The following case, therefore, seems worthy of record.

History.

In July, 1907, I was asked by Dr. F. Pershouse, of Johannesburg, to see in consultation with him a lady, aged 39, who the previous day had shown typical symptoms of acute intestinal obstruction. The history was that three years previously, shortly after confinement, she discovered a lump in the left lumbar region, which caused a certain amount of dull aching pain in the back. She suffered always from constipation, but could obtain relief by means of castor oil. A year ago while in London she had symptoms of obstruction, but apparently not of acute character. Under the advice of a surgeon whom she consulted massage was carried out, with complete relief to the symptoms. From time to time, however, she had left lumbar pain, and always more or less constipation.

Condition before Operation.

When I saw the patient she had been confined twelve days before, having a perfectly normal labour. The facial aspect was anxious; vomiting was frequent, the vomited material being greenish-brown and of inoffensive odour. The pulse was 100, and rising steadily. The abdomen was distended, though not greatly so, and in the left lumbar region a hard movable lump could be felt. It could be felt bimanually to extend into the loin, and was movable antero-posteriorly but not laterally. It was dull on percussion. The impression conveyed was that of a pararenal growth of some kind. There had never at any time been any renal symptoms. The lump extended from the left renal region down to the umbilicus, and over to the middle line. The nature of the swelling was quite uncertain, and beyond a vague suggestion that it was a pararenal "something" no diagnosis was made.

Operation.

The condition of the patient was critical, since no relief had been obtainable by enemata, and the acuteness of the symptoms was hourly increasing. She was therefore removed to a nursing home, with a view to operation. Four hours later, Dr. Pershouse anaesthetizing and Dr. Stanley Heberden assisting, I opened the abdomen in the left linea semilunaris over the swelling. There was no sign of peritonitis. The ascending colon was completely flattened over a large tense swelling, which bulged forward the posterior peritoneum, the colon lying to its outer side. Some large vessels, apparently supplying the colon, ran over its surface. Above, the swelling was apparently continuous with the left kidney, and it extended well over to the middle line. An exploring needle and syringe withdrew pure blood only from the swelling. An incision was made parallel with the vessels through the posterior peritoneum, and an attempt made to shell out the swelling. It was, however, completely fixed posteriorly and above, and a fresh layer was attempted in what looked and felt like a tumour capsule. Suddenly the finger slipped into a large cavity, from which rushed some fluid blood and large masses of blood clot, some recent and some old. The peritoneal cavity had been well packed off, and there was no soiling of the peritoneum. The cyst cavity being thoroughly emptied and sponged out, the cyst wall was stitched all round to the peritoneum of the anterior abdominal wall and the cavity stuffed with gauze. There had been free oozing from the wall of the cyst but this ceased on pressure with the gauze packing. None of the cyst wall was removed, since there was none to spare when the cut edges were brought forward.

After-History.

The subsequent progress of the case was uneventful. Flatus was passed on the following day, but there was no full action of the bowels for forty-eight hours. The cyst cavity gradually and completely closed in a month.

Contents of Cyst.

The material removed from the cyst was submitted to Dr. Pakes, Pathologist to Johannesburg Hospital, and his report was that it was old and recent blood clot with fluid blood.

It seems clear that the origin of the trouble was a retroperitoneal haemorrhage during the confinement three years ago; that at the recent labour a fresh haemorrhage occurred rendering the cyst tense and flattening the colon over it. Precisely the source of the haemorrhage it is difficult to determine—whether from a mesenteric vessel, a renal branch, or a pancreatic vessel it was impossible to decide.

Greig Smith,¹ speaking of cysts of the mesentery, divides them into traumatic, sanguineous, sero-sanguineous, and serous. These arise from rupture of a blood vessel between the layers of the mesentery with extravasation of blood into the areolar tissue. The blood may be diffused or may become encysted, forming a haematoma. The natural changes in clot may result in the formation of a cystic tumour containing liquid blood or blood-stained serum. The rupture of a vessel into a simple cyst may produce a condition identical clinically with a true traumatic cyst. The case in question may, I think, be regarded as a traumatic blood cyst, the traumatism being the straining during labour. The possibility of the blood being of renal origin—that is, from a branch of the renal artery—must be borne in mind. Henry Morris² states that:

Hildebrandt has put on record a blood cyst containing one litre and a half of fluid blood, and not communicating with the renal cavity. He considered it was a haematoma due to rupture of an aneurysm. Blood cysts may occur from accidental rupture of vessels or from the giving way of diseased arteries. They are almost invariably mistaken for renal cysts.

Could the nature of the swelling in the present case have been diagnosed, there is no doubt that drainage through the loin by an extraperitoneal operation would have been the ideal one. Fortunately, however, all went well by the method adopted.

REFERENCES.

¹ *Abdominal Surgery*. Sixth edition. ² *Surgical Diseases of the Kidney and Ureter*.

WHAT CAN THE FAMILY DOCTOR DO FOR THE INEBRIATE?

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It is now generally admitted that inebriety is a disease, and one not easily cured. So refractory, indeed, has it proved that some have asserted that when it attacks the female sex it is incurable. There is no doubt that many doctors have declined to attempt its treatment because they felt hopeless of success. Since, however, the publication in the columns of this JOURNAL of articles setting forth the treatment by hypodermic medication, without the aid of any institution, a few have been induced to attempt it, and with the happiest results.

It may be urged that there is nothing new in this treatment; that the drugs now suggested have been employed for years, and are to be found in every surgery. This is quite true, but seldom in the past has the family doctor set himself to treat inebriety as he would treat any other disease, with the full intention of producing a cure. There is, moreover, a great advantage in the hypodermic method, which renders it certain that the patient gets the drug, and that it enters, not the stomach only, from which it may be at once expelled, but the blood and the general circulation. The regular visits to the doctor are very important. The patient feels that something is being done for him, that his doctor really believes that he is ill, and intends to cure him. The doctor also detects at once how his patient is going on, and whether he is giving up alcohol.

A very useful drug for hypodermic injection in the acute stage of alcoholism is apomorphine. If a patient is suffering from delirium tremens, and in his terrible excitement scarcely restrained by his attendants, and quite unable to obtain any sleep, a small injection of this drug will at once produce a calm. Within five minutes he begins to yawn, and before there is time to get him to bed he is fast asleep. This sleep is sometimes, but by no means always, preceded by vomiting. The patient, if sitting up, is liable to faint, and should therefore be placed in a horizontal position. Five drops of inj. apomorph. hyp. is generally a sufficient dose, and it can be repeated if necessary. Usually about four hours' sleep is thus obtained, and the patient awakes clear and refreshed. But apomorphine is no remedy for alcoholic craving; it is only a temporary measure to control the patient till he comes under the influence of other drugs. It is a very good way of commencing treatment.

When the patient is thus cleared of his delirium and

his drink, he is able to discuss the question of his future, and his doctor will be able to discover whether he has any real desire to give up alcohol or only wishes to be patched up. It is impossible to cure any man against his will, but it sometimes happens that a patient has had no thought of cure, because he deemed it impossible; but when the possibility is placed within his reach he is quite willing to grasp it. In which case the hypodermic injections of atropine and strychnine may be commenced at once.

Many patients, however, are not subject to acute attacks, but continually drink more than is good for them, and, if they try to give it up, the craving for it is so strong that they take to it again. Immediate relief can be given in these cases, and it is quite safe to assure them that within forty-eight hours after the treatment has been commenced the craving will have left them. This assurance is very important, for many of these patients have lost hope through repeated failure in their attempts to cure themselves.

For convenience in carrying out the treatment a mixture of the two drugs liq. atrop. sulph. and liq. strych. hydrochlor., in the proportions of 1 to 4, may be kept in readiness. Five drops of this should be injected into the biceps muscle twice or thrice a day, the patient attending at the doctor's surgery for this purpose.

The patient should also be supplied with a pick-me-up, which he can take whenever he feels low or depressed, or has any craving for alcohol. Four drops of tincture of capsicum, with 15 of liquid extract of cinchona, will answer the purpose. Careful attention must be given to the general health, and the food must be suited to the digestion. A calomel purge is often required at first. Albumen in the urine is not a contraindication. Indeed, it often disappears under the treatment. For the first few visits the patient should be brought by his friends, but after that he will be quite able to pass the public-houses alone. These injections occasionally cause some dryness of the mouth and difficulty of accommodation. A few tablets of potassium chlorate will remedy the former. For the latter, spectacles have sometimes to be worn for close work during the treatment. But the patient can be assured that no injury will be caused to the eyes.

The injections must be given twice a day till the patient has regained health and vigour. This will take from two to four weeks. Then once a day for two or three weeks longer, after which the frequency should be gradually reduced. Under this treatment the general health will greatly improve. The feelings of depression and despair will pass away. The nerves will become steady. The desire for alcohol will go, and a healthy appetite for food will take its place.

The use of such powerful drugs is only safe under the eye of the doctor; but they are absolutely safe in his hands, and no harm comes of the injection except occasionally an appearance of bruising on the arm. I have had several patients return voluntarily for treatment when they had lapsed or felt a return of the craving, but I have never had a patient contract a habit of drug injection.

It is essential that the doctor should keep in touch with his patient for months after the treatment is finished. In this way he will prevent relapse. The patient should be carefully warned against over-confidence. He can never become a moderate drinker again. If at any time a period of mental unrest or depression should come to the patient, a renewal of treatment for a few days will tide him over it. A relapse is not more difficult to treat than the original illness. Indeed, usually a short treatment only is necessary, and the patient is often more cautious for the future. Several of my cases had one relapse, and stood firm ever after.

The patient should be advised as far as possible to avoid the old associations which led to his downfall and seek to have his mind and body occupied in useful work and healthy recreation. The most hopeless cases are those who have nothing to do.

It is stated in the *Allgemeine Wiener medizinische Zeitung* that the Austrian Prime Minister has informed Professor von Jacksch that a new Public Health Bill applicable to the whole empire is actually being prepared, and will be submitted to the Reichsrat at the end of the present year or the beginning of the next.